

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 3 0 4

2. STATE:

VIRGINIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
AUGUST 1, 2003

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 435 and Part 440

7. FEDERAL BUDGET IMPACT:

a. FFY 2004 \$ (1,445,493)  
b. FFY \$

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.6-A, Supplement 3, p 1 of 1;  
Attachment 3.1-A, p1 of 9; Attachment 3.1-B,  
p1 of 8; Attachment 3.1A&B, Supplement 1,  
pp 4.5, 4.6, 9.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

2.6-A, Supp 3: new page  
3.1-A, p1: replaces  
3.1B, p 1: replaces  
3.1A&B, Supp 1, p4.5: replaces, p4.6: ADDS,  
p 9.2: ADDS

10. SUBJECT OF AMENDMENT:

Limit Patient Pay Amounts; Prior Authorize Outpatient Scans

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Secretary, Health and  
Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Patrick W. Finnerty

14. TITLE:

Director

15. DATE SUBMITTED:

August 15, 2003

16. RETURN TO:

Dept. of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

8/27/03

18. DATE APPROVED:

NOV 25 2003

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

8/1/03

20. SIGNATURE OF REGIONAL OFFICIAL:

*[Signature]*

21. TYPED NAME:

MARY T. MCSORLEY

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR  
DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): ALL

**1. Inpatient hospital services other than those provided in an institution for mental diseases.**

☒ Provided: ☐ No limitations ☒ With limitations\*

**2. a. Outpatient hospital services.**

☒ Provided: ☐ No limitations ☒ With limitations\*

**b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.**

☒ Provided: ☐ No limitations ☒ With limitations\*

**c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA Pub.45-4).**

☒ Provided: ☐ No limitations ☒ With limitations\*

**3. Other laboratory and x-ray services.**

☒ Provided: ☐ No limitations ☒ With limitations\*

**4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older).**

☒ Provided: ☒ No limitations ☐ With limitations\*

**b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.**

☒ Provided: ☒ No limitations ☐ With limitations\*

**c. Family planning services and supplies for individuals of childbearing age.**

☒ Provided: ☐ No limitations ☒ With limitations\*

\* Description provided on attached sheet.

TN No. 03-04  
Supersedes  
TN No. 93-04

Approval Date **NOV 25 2003**

Effective Date 08/01/03

HCFA ID: 7986E

Revision: HCFA-PM-92-1  
February, 1992

(MB)

Supplement 3  
Attachment 2.6-A  
Page 1 of 1

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

### ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

#### 12 VAC 30-40-235. Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid

The Medicaid Agency meets the requirements of 42 C.F.R. § 435.725 and § 435.832, and § 1924 of the Social Security Act, in that the agency will deduct amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including medically necessary or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits as follows:

All medical or remedial goods and services not subject to payment by a third party and not covered by Medicaid but recognized under State law, must be prescribed by a physician, dentist, podiatrist or other practitioner with prescribing authority pursuant to Virginia law. The maximum amount that may be deducted from the patient's income for nursing facility residents shall be the maximum amount reimbursed by the higher of either Medicare or Medicaid for the same non-covered items or services.

If neither Medicaid nor Medicare has an allowed amount for the service rendered, then DMAS will protect from individual's income the amount of the provider's charge as billed.

TN No. 03-04  
Supersedes  
TN No. New Page

Approval Date NOV 25 2003

Effective Date 08/01/03

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NARRATIVE FOR THE AMOUNT, DURATION AND SCOPE OF SERVICES

---

3. Other laboratory and x-ray services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Prior authorization is required for the following non-emergency outpatient procedures: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) Scans, and Positron Emission Tomography (PET) Scans. The referring physician ordering the scan must obtain the prior authorization in order for the servicing provider to be reimbursed for the scan. Non-emergency outpatient MRI, CAT, and PET scans that are not authorized will not be covered or reimbursed by DMAS.

4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

*Next page is 6 of 41*

---

TN No. 03-04  
Supersedes  
TN No. NEW PAGE

Approval Date NOV 25 2003

Effective Date 08-01-03

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

**NARRATIVE FOR THE AMOUNT, DURATION AND SCOPE OF SERVICES**

---

- N. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.
- O. The referring physician ordering non-emergency outpatient Magnetic Resonance Imaging (MRI), computer Axial Tomography (CAT) Scans, and Positron Emission Tomography (PET) Scans must obtain prior authorization from DMAS for those scans. The servicing provider will not be reimbursed for the scan unless proper prior authorization is obtained from DMAS by the referring physician.

*Next page is 10 of 41*

TN No. 03-04  
Supersedes  
TN No. NEW PAGE

Approval Date NOV 25 2003

Effective Date 08-01-03

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA  
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND  
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

---

**1. Inpatient hospital services other than those provided in an institution for mental diseases.**

Provided: ☐ No limitations ☒ With limitations\*

**2. a. Outpatient hospital services.**

Provided: ☐ No limitations ☒ With limitations\*

**b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.**

☒ Provided: ☐ No limitations ☒ With limitations\*

☐ Not Provided.

**c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA Pub.45-4).**

☒ Provided: ☐ No limitations ☒ With limitations\*

**3. Other laboratory and x-ray services.**

Provided: ☐ No limitations ☒ With limitations\*

\* Description provided on attachment.

TN No. 03-04  
Supersedes  
TN No. 93-04

Approval Date **NOV 25 2003**

Effective Date 08/01/03

HCFA ID: 7986E